CHAPTER 7

Safety nets

> *[S]afety nets are desirable and necessary if you have copayments, but wouldn't it be nice if we did not need them?*[1]

Introduction

7.1 As outlined in chapter 5, 'A Fairer Medicare' package provides for two additional safety nets: a new safety net for Commonwealth Concession Card holders, and a private health insurance safety net available for everyone. These additional measures are designed to complement the three existing safety net systems under the Medicare system: the Medicare Safety Net; the Pharmaceutical Benefits Scheme (PBS) safety net (not discussed here), and a tax safety net.

7.2 The Medicare Safety Net enables individuals or families whose gap payments (the difference between the schedule fee and the rebate) exceed $319.70[2] in one calendar year, to receive increased benefits amounting to 100% of the schedule fee for any further out-of-hospital costs in that year. The scheme does not reimburse for any amounts charged in excess of the schedule fee, and gap amounts for in-hospital costs do not count toward the limit.[3]

7.3 The tax system also provides some relief in cases of high medical expenses. Once out-of-pocket medical expenses exceed $1500 annually, a person can claim a tax rebate of 20% on that additional expenditure.[4]

The need for additional safety nets

7.4 According to the Department of Health and Ageing, the two additional safety nets are designed to cover gaps in the existing nets. Mr Davies told the Committee that:

> [I]n 2002 there were a lot of individuals and households who faced considerable cumulative out-of-pocket costs despite the cover offered by Medicare. There are about 30,000 households who in that year paid more than $1,000 in out-of-pocket costs for out-of-hospital services. If we focus

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1 Mr Goddard, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 55

2 This amount is adjusted annually for inflation, although what measure of inflation is used to calculate this is unclear.

3 Health Insurance Commission website, Medicare Safety Net, www.hic.gov.au, accessed 25 August 2003

4 Health Insurance Commission website, Financial tax statement, www.hic.gov.au, accessed 25 August 2003. Sen Forshaw, *Proof Committee Hansard*, Canberra 21 July 2003, p. 60

> on the most needy members of our society, we see that there are about 50,000 concession card holders who had costs totalling more than $500 in that year.[5]

7.5 At the same time, the decision to establish the boundary of the second government safety net at $1000 was largely arbitrary:

> It is one of those things where it could have been set at any figure. Obviously, the lower you set it, the higher the cost; the higher you set it, the lower the cost. Ultimately it is a trade-off between costs and benefits. Setting it at $1,000 means that about 30,000 people, we estimate, will stand to use that cover in any one year.[6]

7.6 Addressing the private health insurance safety net, Mr Davies explained:

> The current MBS safety net only recognises the gap between the rebate and the schedule fee, so it is only those payments, which are typically quite small, that count towards reaching the safety net threshold. Indeed, once the threshold is reached in a year, it is only those payments – the gap between the scheduled fee and the rebate – that are covered and are paid additionally under the safety net provisions. So any charges that a provider chooses to levy above the level of the scheduled fee are in effect invisible to the current MBS safety net.[7]

7.7 Mr Schneider from the Australian Health Insurance Association also supported the wider scope for private health insurance on the grounds of equity and practicality. In relation to equity he pointed out that:

> [T]hese charges are already being made. There are people who are very, very sick, who are having to incur quite considerable charges in a whole range of areas … these people are in a position where they have to meet that cost and I do not think it is equitable to deny them the capacity to be able to insure for it.[8]

7.8 Addressing practicality, Mr Schneider explained:

> [T]he way medicine is being delivered today is quite different from the way it was 20 or 30 years ago. It is quite illogical now to confine the operations of the health insurer to the boundaries of the hospital because there are many services which can be performed, probably more safely and better, outside hospital than inside hospital. But the way the system works at the moment is that we have a very perverse financial incentive which

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5 Mr Davies, *Proof Committee Hansard*, Canberra 21 July 2003, p. 4

6 Mr Davies, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 89

7 Mr Davies, *Proof Committee Hansard*, Canberra 21 July 2003, p. 8

8 Mr Schneider, *Proof Committee Hansard*, Canberra 21 July 2003, p. 59

> encourages both the patient and the doctor to admit the patient to a hospital facility … rather than to provide that treatment outside.[9]

7.9 As Mr Davies commented elsewhere, the existing prohibition on private health insurers offering coverage for out-of-hospital costs runs counter to the general trend towards out-of-hospital treatment, which is consequently exposing people to increased financial risk which they cannot insure against.[10]

Criticism of the proposals

7.10 Evidence to the Inquiry outlined four major criticisms of the proposed form of the safety nets. They:

- will cause an increase in complexity and administrative costs;
- will suffer from 'boundary problems';
- in respect to the private health insurance, represent a shifting of responsibility for health care from the public to the private sector; and
- involve inflationary pressures.

Increased complexity and administrative costs

7.11 Some witnesses suggested that adding two further safety net systems onto the existing systems is likely to be administratively complex and potentially confusing to members of the community. As Mr Goddard of the Australian Consumers Association explained:

> From the consumer's point of view, the other drawback of safety net schemes and entitlement schemes is that they tend to be complex. First of all, you have to know that you are entitled to these things. You have to organise your life in such a way that you are able to do the paperwork and make the claims. Some people do that but some don't. The people who do not are not necessarily the people – or their families – who do not need that claim.[11]

7.12 Mr Goddard's view received support from Professor Hall:

> There are always going to be people who do not understand, who do not know and who do not realise or just never get around to it. It may be the people who are least likely to understand the system who are in most need of the safety net provisions. If you could have something that was much

9 Mr Schneider, *Proof Committee Hansard*, Canberra 21 July 2003, p. 59

10 Mr Davies, *Proof Committee Hansard*, Canberra 21 July 2003, p. 89

11 Mr Goddard, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 55

> more automatic, you would have more confidence in the safety net covering all the people it was targeted at.[12]

7.13 On the basis of anecdotal evidence, this point may be borne out in the Department of Health's own experience. Health academic Ms Walker told the Committee that DoHA officials:

> … suspected that a number of people did not claim although they accumulated all the time. They did some inquiries and that seemed to have been due to the fact that a lot of people did not understand the system and they did not know that they could claim.[13]

7.14 In general terms, according to Mr Goddard, any new arrangements must pass the test of simplicity: 'simplicity for the consumer and simplicity for the doctor, the more safety nets you have, the more complex the system becomes …'.[14] Greater complexity means higher administrative costs, as Professor Hall stated:

> We know that if we have multiple payers in the system we are likely to have much more administrative overhead. It just costs more to have more payers. More systems have to be set up and more sorts of checking routines.[15]

7.15 The AMA concluded:

> The proposed dual safety net scheme is complex. The population will find it hard to negotiate. AMA advocates a safety net scheme which approaches from the patient's point of view and which provides support to those with poor health status (more often than not, those with a poor socio-economic status). This could well indicate a single safety net spanning both Medicare and the PBS. Access to the safety net should be at three levels: pensioner, health-care-card holder and non-concessional.[16]

7.16 The Western Australian government arrived at a similar view:

> [A]side from being confusing and in all likelihood not well understood by the general public, a more equitable approach would be to have the one scheme for all patients.[17]

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12 Professor Hall, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 57

13 Ms Walker, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 57

14 Mr Goddard, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 55

15 Professor Hall, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 44

16 AMA, Submission 83, p. 6; see also RACGP, Submission 86, p. 6

17 WA Government, Submission 177, p. 11

Boundary problems

7.17 A related problem is that a system of safety nets, focusing benefits on certain defined groups, tends to create winners and losers. This problem is most obvious at the boundaries of entitlement, especially for those who just fail to qualify. A key issue in this respect is the creation of the second safety net for concessional patients only, and the preceding chapter has already examined the problems inherent in using concessional status as a measure of need in the context of bulk-billing programs.

7.18 Mr Goddard gave evidence of research by the Consumers Health Forum on the safety net and its impact on out-of-pocket patient costs in the Pharmaceutical Benefits Scheme:

> It found that the people who just fell outside the concessional safety net scheme were substantially worse off, even though they had nominally higher incomes, than those who were covered by the concessional scheme. That is always one of the drawbacks with any scheme that falls short of universality. There are always going to be people just over the edge who fall outside and who tend not to be identified as needy, but who can quite often end up being far more needy than, for example, pensioners, the unemployed or the underemployed.[18]

7.19 The findings of this research seem to be borne out by evidence from Ms Walker of the National Centre for Social and Economic Modelling (NATSEM):

> We found that concessional patients on average pay less than two per cent of their after-tax take-home income. For general patients, the average goes up to about four or five per cent. But for the poorest of the general patients, when we divided the population by five, in 2000 it was about six per cent. … But then we did some projections to 2005 on the basis of the already announced increases in copayments, which were then CPI-related, and it was getting to about nine per cent. That is a huge amount for a relatively poor family.[19]

Transferring responsibility to the private sector

7.20 A further concern that relates specifically to the proposed private health insurance safety net is that it represents a general shift of responsibility for health away from government and to the private sector. This concern was expressed by the AMA:

> This proposal for private health insurance for out-of-hospital out-of-pocket medical expenses is a further implementation of the Government's implicit strategy of progressively shifting more of the burden of medical costs from Medicare to private health insurance.

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18 Mr Goddard, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 55

19 Ms Walker, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 58

> The potential risks to the clinical independence of practitioners and their capacity to deliver clinically appropriate and high quality health care ensures that there is little support for this proposal. The AMA remains opposed to any measure that might encourage managed care to become a feature of the Australian health system. This proposal has that potential.[20]

7.21 The Hon. Wendy Edmond, Queensland Minister for Health shared this concern telling the Committee that: 'we are seeing an ideologically driven pressure to move more and more into the privatisation of health services and health service delivery.' [21]

7.22 According to Professor Deeble, the private health insurance safety net operates as a mechanism for transferring responsibility to the private sector by implicitly giving the government a way of avoiding responsibility for meeting rising health care costs. As costs rise, the government can leave rebate levels alone and allow the private health insurance to meet the rising gaps:

> There is a clear option here to say, 'We in the government and in the department know that there is a safety net which people pay for. So we can let the gaps grow a bit – we can freeze our rebate – and we know that it won't hurt anybody very much, and the rebate and the safety net exist for those people who are hurt.' And you do not pay the full amount of that; you pay only 30 per cent of it.[22]

7.23 Expanding the role for private health insurance in out-of-hospital expenses also introduces additional capacity for private health insurance companies to control treatment patterns by GPs, as alluded to by the AMA in the quotation above. This can amount to the introduction of powerful new policy players in the health care equation. For many Australian doctors, this raises the spectre of 'managed care' as practised in the USA. Dr McBryde related his experience in the United States:

> [I]n almost every practice that I went to I found that the general practice had to employ a full-time person just to deal with what can and cannot be done and to deal with questions with regard to what the claims are, how you claim it back and what will be paid. It is an absolute nightmare.[23]

7.24 Dr Kastrissios reported on his discussions with a practitioner from Florida in the United States, whose:

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20 AMA, Submission 83, p. 7

21 The Hon Ms Edmond, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 20

22 Professor Deeble, *Proof Committee Hansard*, Canberra 21 July 2003, p. 63. See also WA Government, Submission 177, p. 12

23 Dr McBryde, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 99

> general practice routinely employed one coder and one staff member – two people – to handle the claims of the five or six HMOs, insurance companies, to which he was affiliated. He felt it was nightmarish.[24]

7.25 Dr Kastrissios also noted the problems that have already arisen in Australia, that would be likely to worsen:

> Our relationship as GPs with private health insurers is often problematic in that we are forced to be in a patient advocacy role defending the person's claim, and it becomes extremely difficult to manage that process. We are small business operators; they are big corporations with teams of lawyers. We have experiences with private health insurance companies that are not always positive.[25]

7.26 From the medical community, there is a strong view that the American experience of private insurer control over medical practice is one to be avoided in Australia.[26]

Inflationary pressures

7.27 The final issue relates to the concern that the availability of private health insurance to cover gaps will remove what has been a constraint on doctors' fees. Dr Boffa of the Aboriginal Medical Services Alliance of the Northern Territory (AMSANT) told the Committee that:

> Any move to gap insurance, any use of the private sector to fund health care and any system that says to GPs, 'You can charge what you like and health insurance companies will fund it,' will lead to them charging more.[27]

7.28 Similarly, Mr Goddard of the ACA commented:

> There is a substantial opening for moral hazard – for instance, for doctors, and specialists in particular, to structure their charges in such a way as to bring people up to the $1,000 threshold quite quickly so that they could then claim on the insurer. To the extent that that happened, it would put quite a lot of pressure on the insurer and quite a lot of upward pressure on premiums.[28]

7.29 Mrs Kendell of the Health Consumers Network expressed concern about the effect of inflationary pressures:

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24 Dr Kastrissios, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 99

25 Dr Kastrissios, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 99

26 See also, for example: Ms Dorron, *Proof Committee Hansard*, Bundaberg, 25 August 2003, p.40; Dr Churcher, *Proof Committee Hansard*, Melbourne, 27 August 2003, p. 60; Dr Gault, *Proof Committee Hansard*, Melbourne, 27 August 2003, p. 59

27 Dr Boffa, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 52

28 Mr Goddard, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 55

> Does the government not realise the proposed $1 extra a week to insure the gap for all medical out-of-pocket out-of-hospital expenses will very quickly soar when doctors start charging blue-sky fees, knowing their patients' private insurance will pay for them? While the government is suggesting that gap cover will add only $52 annually to the current costs for private insurance, an American family of four pays as much as $US13,000 annually for this sort of coverage.[29]

7.30 This argument was rejected by representatives of both the private health insurance industry and the government, on the simple grounds that a doctor does not necessarily know which patients are insured nor the level of reimbursement. Furthermore, as Mr Schneider explained:

> [I]f either the health insurance industry or the Health Insurance Commission discovered that the medical profession was exploiting any arrangement which was intended to cover catastrophic illness, I would be back in this room as quickly as I could possibly be, seeking some further refinement of the legislation to reduce the prospects of that continuing. … at this stage I think I am fairly confident that there are sufficient checks and balances in the system to preclude the sort of abuse that would concern all of us.[30]

7.31 In supporting this view, the Department of Health and Ageing noted that the HIC has the information that would enable them to detect cases where the same provider charged different prices for the same service before and after crossing the $1,000 threshold (although they do not currently do so).

7.32 Mr Davies, representing the Department, went on to argue:

> This product is 'catastrophic cover.' It is a premium which the insurance people call a high deductible premium: you have to have paid $1,000 out of your own pocket before you become eligible to claim under these policies. We estimate 30,000 people per annum will benefit from that and for those people it is a very valuable product, but actually I know that is substantially less than one per cent of the population. So the opportunity for doctors, particularly specialists, to increase their fees in response to the existence of this product seems to me extremely unlikely. They will not know who has already crossed the threshold, because they have no way of knowing that.[31]

7.33 Mr Davies also observed that the danger of inflationary effects of the safety nets is further ameliorated by the fact that the small number of patients who reach the safety nets are likely to have incurred expenses from a range of medical specialists

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29 Mrs Kendell, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 2; see also WA Government, Submission 177, p. 11

30 Mr Schneider, *Proof Committee Hansard*, Canberra 21 July 2003, p. 68

31 Mr Davies, *Proof Committee Hansard*, Canberra 21 July 2003, p. 68

and not just from a single doctor. As such, doctors will generally be unaware that patients have reached the safety net.[32]

7.34 Finally, the Department is able to draw on its experience with the operation of the existing safety net arrangements:

> … if doctors were in the habit of finding patients who had crossed the safety net and increasing their fees to capitalise on the lower price sensitivity of such patients, then we might expect to see, in current data, prices for equivalent services going up for patients who have crossed the safety net. Some very recent analysis that we have carried out suggests that that is not happening. That is as close as we can get to concrete evidence that the medical profession is not in the habit of pumping up its prices once people have crossed the safety net.[33]

7.35 Accurately judging the extent of any inflationary effects is complex, and this was one of the issues on which the Committee commissioned research from the Australian Institute for Primary Care. In their findings, the AIPC authors found that:

> It is extremely difficult to assess the actual inflationary impact of such a measure, since the actual cost to individuals will be dependent on the costs of the insurance product, which will also depend on the characteristics of those taking up the insurance product.
>
> Similarly, the provision of a publicly funded 'safety net' set at $500 per annum (indexed) for out-of-pocket costs to concession cardholders may induce some inflationary effects, but it is extremely difficult to assess these. It is unlikely that inflationary effects (if any) arising from these initiatives will impact at the level of GP fees. It is possible that some specialist medical practitioners providing frequent services to regular patients may identify an opportunity to increase fees.[34]

Conclusion

7.36 Arriving at a final view on the proposed new safety nets is not an easy exercise. The Committee recognises that there are gaps in the existing safety net arrangements, which potentially leave some people with no choice but to pay significant out-of-pocket costs. However, it also considers the establishment of two additional layers of safety net to be inefficient, likely to increase the overall administrative costs and to cause further confusion to the intended beneficiaries of the scheme, particularly in the wider context of safety net arrangements under the Pharmaceutical Benefits Scheme. On this point the Committee is also concerned that the very people who most need the safety nets may also be those whose access is compromised by bureaucratic complexities.

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32 Mr Davies, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 70

33 Mr Davies, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 91

34 AIPC Report to the Senate Select Committee on Medicare, September 2003, p. 35

7.37 The chapter considered the danger of 'boundary problems' – of people 'falling through the cracks' of the system. These problems are inherent in any differentiated system that steps away from the principles of universality and, in this respect, revisits many of the arguments made in relation to bulk-billing made in the preceding chapter. The Committee notes here the comments of Mr Goddard:

> The role of safety nets is inextricably linked to copayments and a lack of access and a lack of equality of access. The more satisfactory access is, the less need there is for a safety net. However, safety nets become essential if there is going to be a significant level of copayment or out-of-pocket expenses.[35]

7.38 There is the danger a system focusing on safety nets implicitly serves to separate the wealthier part of society from the benefits of a system they continue to pay for. This was expressed by the Hon. Wendy Edmond:

> We all pay taxes, and then people start objecting to paying for a safety net system at the same time as they are paying large amounts for private health insurance and, on top of that, copayments. So cuts happen in those areas that general taxes go towards. That is what happens in the United States. People object to increasing public health care and improving the quality of it for those who are left behind.[36]

7.39 On the evidence presented, the Committee does not consider inflationary pressures to be a significant concern arising out of the proposed safety nets. However the Committee does share the concerns of the many doctors who fear the potential for increased control over primary care by private health insurers. As Dr Gault, a GP in Port Fairy put it: 'It would be much worse than the HIC would ever be.'[37]

7.40 The Committee is also sceptical of the effectiveness over time of any reliance on private health insurance safety nets. Experience has shown that rapid rises in private health insurance premiums are likely to erode the affordability of the proposed net for many families, and again, it is those on the boundary – the working poor – who are likely to feel the greatest financial impact.

7.41 Overall, the Committee believes that any consideration of the issue of safety nets must be underpinned by a commitment to the principle of universality and the role of Medicare as a properly funded public insurer. Put into practice, this commitment removes much of the need for safety nets in the first place. However, to the extent that there is a need for safety nets, the Committee considers that any reform should focus on creating a single, simple, and automatic payment system. This would parallel the arrangement for safety nets under the Pharmaceutical Benefits Scheme,

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35 Mr Goddard, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 55

36 The Hon Ms Edmond, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 20

37 Dr Gault, *Proof Committee Hansard*, Melbourne, 27 August 2003, p. 59

minimise the wastage of administrative costs, and ensure that those who need the assistance actually receive it.

Recommendation 7.1

The Committee recommends the Senate reject the proposal for an additional safety net that differentiates concessional and non-concessional patients.

Recommendation 7.2

The Committee recommends the expansion of the existing Medicare Safety Net to provide for all out-of-pocket costs in excess of a set amount.

Recommendation 7.3

The Committee recommends that this amount be indexed annually to ensure that the safety net reflects the real costs of health care.

7.42 Were this proposal implemented, it would render the second proposed private health insurance safety net unnecessary.